

Small Applied
Research No. 10

**Priority Service
Provision under
Decentralization: A
Case Study of
Maternal and Child
Health Care in
Uganda**

December 1999

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Partnerships
for Health
Reform



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Partnerships
for Health
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The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *Better informed and more participatory policy processes in health sector reform;*
- ▲ *More equitable and sustainable health financing systems;*
- ▲ *Improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *Enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

In 1993, Uganda began decentralization of its health care sector to the district and subdistrict levels. Its objectives were to increase local revenue for health service provision, in part through user fees; involve the consumers in the management of their health care services; and integrate all providers, including non-governmental organizations, missions, and non-traditional providers, into the care delivery system. The increased revenues and consumer participation was expected to improve quality and increase utilization of services.

With a focus on maternal and child health (MCH) services, this study used statistical data and interviews with local health administrators and physicians to assess how the reform policies have been implemented and how they have impacted MCH service provision and utilization. It found that user fees are relatively high for MCH services; increased local revenue has failed to materialize because people are reluctant or unable to pay user fees, and those revenues that are raised go to the district level for reallocation elsewhere; and local facilities in reality still have little decision-making and implementation authority because their need for health care financing forces them to turn to international donors and vertical programs.

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Acronyms

DANIDA	Danish International Development Agency
HUMC	Health Unit Management Committee
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
OPD	Outpatient Department
PHC	Primary Health Care
PHR	Partnerships for Health Reform
TBA	Traditional Birth Attendant
USH	Uganda Shilling

Exchange Rate

Uganda Shilling 1000 = US\$ 1

Foreword

Part of the mission of the Partnerships for Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact.” This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The main objective of the Applied Research program is to prepare and implement an agenda of research that will advance the knowledge about health sector reform at the global and individual country levels.

An important component of PHR’s applied research is the Small Applied Research (SAR) program. SAR grants are awarded, on a competitive basis, to developing-country research institutions, individuals, and non-profit organizations to study policy-relevant issues in the realm of health sector reform. The SAR program has twin objectives: to provide data and analyses relevant to policy concerns in the researcher’s own country, and to help strengthen the health policy research capacity of developing country organizations. While PHR provides technical advice and support to the SAR grantees, the content and conclusions in the final research reports are the responsibility of the grantees. They do not necessarily reflect the views of USAID or PHR.

A total of 16 small research grants have been awarded to researchers throughout the developing world. Topics studied include health financing strategies, the role of the private sector in health care delivery, and the efficiency of public health facilities.

SAR grant recipients are encouraged to disseminate the findings of their work locally. In addition, final reports of the SAR research studies are available from the PHR Resource Center and via the PHR website. A summary of the findings of each study are also disseminated through the PHR “in brief” series.

Small Applied Research Grants

Dr. Joseph K. Konde-Lule (Institute of Public Health, Makerere University). “User Fees in Government Health Units in Uganda: Implementation, Impact and Scope.”

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To the rest that I have not mentioned, I should say thanks, and I take all responsibility for any errors of omission, commission, or otherwise.

Executive Summary

Decentralization of government tasks, authorities, and resources is a precondition for improving basic health services by providing the required institutional framework for improvements in service delivery. Reform initiatives focus on giving more political and administrative autonomy to decentralized districts; raising local revenue for health services (through user fees); involving health service consumers in the management of health service delivery, and integrating all other health service providers (non-governmental organizations[NGOs]/missions and traditional health providers).

The assumption is that consumers of health services will effectively supplement the state's efforts to revamp the health service sector, by directly contributing to sector functioning by way of planning and management (through decentralization) and financial contributions (through user charges).

This study does not examine all the effects of decentralization's intended benefits, but rather examines its impact on one specific area: maternal and child health (MCH) services.

The main hypothesis is that MCH, a priority health need of the most vulnerable groups—women and children, who form the majority population—should benefit from the interrelated changes associated with the new policy. Specifically MCH should benefit from the increased financial resource allocations and priority setting at the local level.

The study set out to verify this hypothesis in two deliberately selected districts—Rakai and Mukono. These two districts can be considered the “best scenario,” both of them having been among the first batch of 13 districts to be decentralized in 1993.

Objective

The main objective of this study is to assess how the new health policy changes impact on the provision and delivery of maternal and child health services in two selected districts. The assumption is that MCH, a priority health need of the most vulnerable groups—women and children, who form the majority population—should benefit from these interrelated policy changes. More financial resources should be allocated to MCH services, people should participate more, and there should be a general upward trend in service utilization.

Methods

The study was carried out from two districts, Rakai and Mukono, selected from Uganda's 45 districts. Both are pilot districts for the decentralization policy.

Data collection instruments in form of questionnaires, code sheets, summary sheets, and checklists were used to collect the data needed. Policy documents and expenditure budgets at the various levels, district and sub-county, were accessed and analyzed.

A representative sample of 10 health units was randomly selected from each district. The other data came from offices such as the district and sub-county offices. Key informant interviews were done with district civil servants and local leaders.

Data analysis was quantitative and qualitative, with statistical tables and figures used alongside qualitative narratives such as policy statements.

Main Findings

Decentralization has already realized tremendous success over a wide range of issues. More political and administrative powers have been granted to the districts. However, the envisaged bottom-up approach to policy formulation and decision making has remained elusive. Often local governments are only consulted, rather than asked for real input, or simply invited to provide support for the implementation of vertical programs.

Increased local revenues for health services also have failed to materialize: districts still lack authority to increase allocations of local funds to maternal and child health services. Also contrary to the expectations that MCH services would tremendously benefit from policies related to decentralization, user fee rates, though entirely decided upon by districts, negatively impacted utilization of MCH services. User fees seem to be out of reach of many would-be users of MCH service and possibly this explains the low and declining utilization trends.

1. Introduction

Current health care reform policy focuses on four major issues:

- ▲ Decentralizing services to the districts,
- ▲ Raising local revenue for social service provision (health services inclusive)
- ▲ Increasing the participation of health service consumers in the management of health services;
- ▲ Integrating of all other health service providers (non-governmental organizations [NGOs], missions, and traditional health providers) into the mainstream of health service delivery.

The assumption is that users will effectively supplement government efforts to revamp the health service sector, by directly contributing to planning and management (through decentralization) and financial contributions (through user charges).

These assumptions can better be analyzed only if one puts them into the general context of health service provision and the whole policy environment.

1.1 Uganda's Health Policy Environment and Policy Changes

Government support for social services, principally health, has declined radically from the early 1970s. The deterioration of the health service system in Uganda is partly attributable to the complex legacy of bad post-colonial rule, which helped to push the country into political, economic, and social turmoil from which it may only now slowly be recovering. The effects of the turmoil on service provision were devastating and, as a result, Uganda's aggregate health indicators, such as infant mortality and life expectancy at birth, are today among the world's worst.

Government's capacity to deliver social services is further hampered by a low revenue base and therefore few resources for expenditure on public sector social services. This is further exacerbated by an ineffectual prioritization, lack of a "living wage" for government employees, and extremely poor working conditions. There are significant systemic and structural inequalities in both the placements of facilities and accessibility to health services in Uganda, between urban and rural areas and within them. Conditions in almost all public facilities have deteriorated, and there exists little effective management. The management issue is, though, mainly a matter of motivation. It is also a reflection of the poorly coordinated structure of responsibility for health services in Uganda. It is also, arguably, a reflection of Uganda's moral decay and corruption.

Several scholars have argued that by 1962, Uganda, with 27 hospitals and a staff establishment of 1,288 serving a population of 7 million people, offered the best health service network in sub-Saharan Africa (Nabuguzi, 1995; Owor et al., 1987). With the addition of 22 hospitals during the successive years of independence, Uganda's health service system was steadily growing and quite promising. At that time, the state perceived of itself as the motor of development and the provider of services. It therefore set out to centralize political and economic activity, secularize education and

health institutions, and restrict non-state activity in general. Its role as the provider of services had a profound effect on people's expectations from the state.

In the period 1971–1986, the advent of Idi Amin and the instability that followed his deposition, led to economic decline and anarchy. This in turn led to the collapse of the state services. Hospitals were critically affected by the expulsion and emigration of trained personnel; from 1972 to 1996 the number of doctors decreased from 1,171 to 964, and the doctor to population ratio increased from 1:9,090 to 1:20,228. Though the number of nurses increased slightly, from 3,877 to 4,059, their ratio to the population decreased from 1:2,745 to 1:4,804. Likewise, the midwives and medical assistants to population ratios also worsened, from 1:3,817 down to 1:7,431 for midwives; and from 1:24457 to 1:29367 for medical assistants. For rural health centers and dispensaries, which never had resident doctors or pharmacists, lack of medical supplies seems to have been the most severe problem. A 1988 report by the World Health Organization (Carrin, 1988) estimates that attendance at government health units dropped by half between 1976/77 and 1988, and attributes this to gross shortages of drugs. As we shall see later, drug shortages and related problems such as drug leakage have posed a big challenge to the rehabilitation and revamping of the state service delivery system.

Private and informal health care enterprises, with personnel also employed in government health service, emerged to meet unsatisfied social needs, and self-medication rose tremendously. Traditional medicine, which predates the advent of western medicine and had been legislatively restricted by the colonial government to only “localized use,” became a renewed force during this period. Likewise, miracle healing claims by various religious sects and cults gained more prominence and followers than ever. This has resulted in ill health among Ugandans who have sought ineffective medication for otherwise curable diseases.

By the early 1980s, the health service sector had worsened beyond the most pessimistic prediction. Insecurity and civil strife worsened, the economy rapidly declined, and state-run services collapsed, giving rise to a complicated informal health service sector as well as self-medication, with the state health personnel at the center of it.

In 1987, after many years of decay not only in the service delivery system but also in the general political-economic sphere, the newly installed National Resistance Movement government appointed a 13-man Health Policy Commission to review, examine, and inquire into the health system and policy with a view of recommending reforms. The commission considered views from 260 individual respondents, several interest groups, over 150 memoranda, as well as more than 50 papers. Commission recommendations included the following:

- a) Implementation of primary health care policy through intersectoral and interministerial collaboration;
- b) Improvement in maternal and child health (MCH) services by ensuring that all health care units in the country provide such services, including family planning, and training and support of traditional birth attendants;
- c) Decentralization of authority and financial control to the districts
- d) Close cooperation between the Ministry of Health (MOH) and traditional practitioners;
- e) Alternative sources of financing for the health sector, mainly through cost-sharing; and
- f) Community participation through health committees.

During the years following the commission's report, government seemed keen on implementing its recommendations, but had little success. In 1989, government attempted to increase financing for health by instituting user fees (cost-sharing). The Parliament defeated the effort, and the government shelved it.

In 1993, a government White Paper on Health (Ministry of Finance, 1993) stressed primary health care as the main objective. However, allocation of funds did not reflect this priority. Most government funds were allocated to curative services, leaving only multilateral and bilateral donor funds for primary health care. Actually for the years 1992–96, donor funds for primary care averaged 82 percent of their total recurrent health budget, while government only allocated an average of 22 percent. Also in 1993, decentralization was initiated in 13 districts on an experimental basis. Under the decentralization policy, the districts were mandated to formulate, approve, and execute their own development plans. Such plans were to be comprehensive, incorporating plans of lower local governments (sub-counties), fit within the structure of the National Development Plan, and be submitted to the National Planning Authority. Implementation and supervision of decisions were to be made at the district level. Further mandate was granted to districts to raise finances, in conformity with the concurrence of the sub-counties, through fees and taxes, receiving donations, or taking loans not exceeding 25 percent of locally raised revenue.¹ Districts would then formulate, approve, and execute their own budgets.

In 1997/98 districts were also granted authority to run district hospitals in addition to health centers, dispensaries, and aid posts; primary health care; and maternal and child health care. In conformity with national policy guidelines, districts could also determine the structure of the district civil service, establish or abolish offices in the district public service, recruit and move employees, and pay salaries.

In light of the limited potential for increasing government resources for health, the MOH has drafted a national health policy for 1997/98 to 2006/07 (MOH 1998a) emphasizing primary health care and the rapid establishment of health sub-districts throughout the country, with integration of all health service providers—NGO/mission, private, and traditional practitioners—at the core of this policy. Though the problem of limited funding from the central government is highlighted, no alternative sources of funding are suggested. The policy carefully avoids the controversial issue of user fees but emphasizes “local government” funding initiatives as alternative sources of additional funding for health. Obviously, this implies user fees since districts have very few and limited alternative sources of funds.

1.2 Decentralization—Still a Long Way to Go

Uganda's decentralization policy, coupled with liberal political, economic, and social reforms at a time when the country is emerging from civil strife and bad governance, social and economic slump, as well as poverty and corruption all pose challenges of implementation and raise several salient issues. This paper considers decentralization in light of social service provision with emphasis to health services.

Despite the partial achievement of decentralization on the one hand and political rhetoric on the other hand, planning and determination of priorities still lies with the central government or the

¹ District revenue sources are very limited.

various aid agencies.² Actual political power at the district is not matched with actual resources. Local revenue sources are limited. Central government financing comes with strings attached, leaving decentralized districts with very few options. With donor-funded activities, often the largest part of the district budget, districts must work within the donors' conditions and priorities; each donor defines the priorities, sets the targets, and plans how to execute their plans. This is reinforced by lack of organizational and management skills and corruption within the central and district civil service, which forces aid agencies to maintain a presence in the districts to implement and monitor their programs and to channel aid outside of the mainstream government structure. Already, donor aid is being channeled through the MOH, then to the districts, and finally to the NGOs for implementation. And here, NGOs choose what to implement and what not. They also choose to fund certain activities and not others even when they are closely linked. For instance, NGOs/donors might not pay staff salaries, arguing that this is a recurrent expenditure, but would fund field trip allowances, fuel costs, stationery, etc. Obviously this changes staff focus and orientation to activities that maximizes their benefits.

Raising enough revenue through taxation from poor populations is bearing limited fruits. Recovery and expansion of ruined economic activities (mainly agriculture) is not happening fast enough. Areas that relied on cotton for example may never succeed in reviving that sector. Even those that previously relied on coffee are not much better off. In Rakai district for example, local revenue was less than USH (Ugandan shilling) 1 billion from a population of about 400,000 people (as of the 1991 national census³). Obviously this is quite low and realistically there is little that may bail out the district in the near future. The district officials attribute this to a number of factors, including widespread poverty, a narrow tax base, and climatic shocks such as the El Niño rains. In such circumstances it is difficult to expect raising revenue through user fees.

1.3 User Fees (Background)

User fees have been a subject of controversy for quite some time. In 1912, the colonial governor, Sir Coryndon, suggested charging fees in public health units. This was objected to by a wide section of the population and consequently the colonial government dropped the suggestion. Similarly in 1939, Lord Hailey failed to persuade the Directors of Medical Services in East Africa to introduce fees in public health units. A commission of inquiry into the possibility of charging health service users, among other issues, was again appointed in 1959 by Sir John Croot, the then-minister of health. Though the commission recommended for the introduction of some charges, they did not materialize.

As noted above, in 1987 the Health Policy Review Commission recommended for the introduction of user fees in public health units. The recommendations were supported by a congress of district local leaders and district administrators. Subsequently in 1989, government issued a White Paper on the commission's report and an interministerial committee (Cost-Sharing Coordination Unit) was set up to refine the issues and recommend modalities for the operation of the scheme.

The unit conducted public campaigns and drew up plans to initiate the scheme. In 1990, however, Parliament failed to pass user fees into law at the national level and consequently the government shelved the proposal. It was only in 1993 that the decentralized districts were given the mandate to take it up on their own. However, the guidelines issued by the Cost-Sharing Coordination Unit were yet to be internalized in the district health system, the Health Management Committees

² Districts make their annual plans in close consideration of the president's manifesto.

³ Uganda's population growth rate is 3.4.

were not yet in place, and generally there was little preparation for user fees. Districts had to redesign the scheme to suit local conditions and legitimize the scheme. Implementation remained largely dependent on the innovative skills and other circumstantial advantages associated with individual health units. Rates varied between health units, and in some units there were no charges.

Recent studies on the subject have raised more controversy and questions than answers. Information on willingness and ability to pay is scattered in various reports. Most reports have claimed that there is a willingness and ability to pay but have not produced evidence to back such claims. This is of course a complex issue. Nevertheless, poverty profiles can be used. A more recent study on poverty by the government of Uganda, funded by the UK's Department for International Development, shows that user fees have erected a barrier to utilization (Ministry of Finance, 1999).

Several other studies on user fees (Mwesigye-Runumi, 1995, 1997; Konde-Lule and Okello, 1998; Kisubi and Mugaju, 1999) have claimed that user fees have made funds available for supplementary drugs, paying of "top-up" allowances to the health workers' salaries, rehabilitation of health units, and construction of new buildings. At Kawolo hospital in Mukono district for instance, the doctors' "top-up" allowances from user fees are USH 10,000 to supplement their low salaries of USH 249,454/month for senior nursing officers/doctors-medical officers, and 430,698/month for senior doctors-medical officers. In Rakai district, only USH 35,000 on average was being spent on drugs every month. Certainly this is too small to make any meaningful supplements to the drug stocks.

On the one hand the general policy is one of revamping the health sector, while on the other hand the policy instruments like user fees, whose benefits are difficult to see, may have adverse effects on utilization. This is especially true in situations where the quality of services has not improved (recurrent drug shortages still occur), where user fees have not managed to supplant the "under the table" payments, and where the health staff continue to be poorly paid and in some instances not paid any benefits.⁴ Popularizing and legitimizing such a policy instrument, moreover after its 1990 defeat in Parliament, is an uphill task for the districts where there is little or no improvement in service delivery, and for MOH policymakers. To gain popular acceptance of user fees, central and district policymakers are proposing to use the new revenue for purchasing supplementary drugs, topping up staff salaries, and carrying out rehabilitations of facilities.

⁴ Central government phased out certain categories of staff during the civil service reform. Except in Mukono district, one category of staff (nursing aides) has been paid from the district's own funds.

2. Study Objectives and Methodology

The main objective of this study is to assess how the new health policy changes impact on the provision and delivery of maternal and child health services in two selected districts. The hypothesis is that MCH, a priority health service that benefits the most vulnerable groups (women and children, who form the majority population) should be advantaged by the interrelated policy changes cited in Section 1. Financial allocations to MCH services should be increased, people should participate more in decision making, and there should be a general upward trend in service utilization.

2.1 Specific Objectives

- ▲ To examine the constituent elements of local administrative structures and their capacity to raise funds on the one hand, and allocate them on the other.
- ▲ To examine the relationship between revenue collection, budgeting process, management capacities and accountability at the local level in relation to the provision MCH services.

2.2 Methodology

2.2.1 Study Areas

The study was carried out in two districts, Rakai and Mukono, selected from Uganda's 45 districts. Both are pilot districts for the decentralization policy. This allows in-depth insights into the changes resulting from this policy.

2.2.2 Data Needs and Data Collection

Data collection instruments in the form of questionnaires, coding sheets, summary sheets, and checklists were used to collect data from the various health units and district administration offices: the district medical office, district personnel office, and the chief administrative office. Key informant interviews with several department heads in the district administration and local leaders were carried out. Policy documents, district annual plans, and expenditure budgets were accessed and analyzed.

Interviews were also carried out with the various hospital superintendents, heads of departments, and those in charge of the lower health units (health centers and dispensaries). Immunization and attendance records as well as financial records of income and expenditure from the user fees were accessed and analyzed.

2.2.3 Sampling

A representative sample of eight health units was randomly selected from each district. Since each district has only two public hospitals, both hospitals from each district were also sampled, bringing the number of health units in each district to 10 in total.

2.2.4 Data Analysis

Data was analyzed quantitatively by use of simple computations and qualitatively by critical analysis of policy statements and service utilization trends. Statistical tables and figures were used alongside qualitative narratives.

3. Main Findings

3.1 Introduction

This section gives the main findings of the study. It is divided into three main categories: user fees, health budgets, and utilization of maternal and child health care services.

3.1.1 User Fees

User fees are the only financing scheme through which districts have hoped to mobilize their own funds to supplement their budgets for health service delivery. Thus far, the fees have contributed only very little to district revenue. For instance, in Mukono district, where user fees revenue is integrated into the district budget, fees represented only 3.5 percent of the total local revenue.⁵

At the lower level health units, charges are quite simple: Each patient is charged USH 500 on the first visit. In hospitals and health centers (second line units) charges are more complicated and quite unclear to users. Usually, these facilities charge for several services; there are consultation fees, inpatient fees, laboratory tests fees, maternity fees, X-ray fees, etc. Sometimes there is also a fee for services in the private wing. Fee amounts range from USH 500 for a single consultation to USH 20,000 when a patient receives multiple services at once. Notably, MCH services are among the most costly services, as shown in Table 1 and Table 2.

Table 1 shows the structure of fees in Kayunga and Kawolo hospitals, Mukono district. Table 2 shows the structure of fees for Rakai and Kalisizo hospitals in Rakai district (these hospitals had a similar fees structure).

⁵ Mukono district collected approximately USH 3.4 billion in local revenues, while Rakai district managed to collect only about USH 1 billion.

Table 1. Fee Structure of Kayunga and Kawolo Hospitals, Mukono District (in USH)

Kayunga Hospital		Kawolo Hospital	
Grade A*			
Outpatient department (OPD)	1,000		
Inpatients (per night)	1,000		
Private ward	3,000		
Grade B*			
OPD	500	OPD	500
OPD (children under five)	500	OPD (children under five)	500
Inpatients (per week)	2,000	Inpatients	
Dental services (children and adults)	1,000	Dental services (dental asst.)**	1,000
Antenatal (first visit)	500	Dental services (dentist)	1,000
Antenatal (revisit)	300	Antenatal (first visit)	1,500
Ultrasound	2,000	Antenatal (revisit)	500
Normal delivery	5,000	Antenatal medical check-up	1,000
Twin delivery	7,000	Postnatal attendance	500
Manual vacuum extraction	5,000	Normal delivery	3,500
Cesarean section	7,000	Manual vacuum extraction	5,000
More than one hernia	1,000	Cesarean section	10,000
Single hernia	20,000	Major operation	10,000
More than one hernia	10,000		
Fracture patients	20,000		
All major cold cases	5,000		
All major emergency cases	20,000		
Major surgical wounds	20,000		
X-ray services	10,000		
Laboratory tests per specimen	500		
Minor operations		Minor operations	
Incision and drainage	2,000	Urinalysis (urine test)	500
Surgical toilet and suture (small wounds)	2,000	Stool analysis (stool test)	500
Bouginage	5,000	FBC + ESR (full blood count + ESR)	1,000
Extraction of FBs from external cavities	2,000	WBC (White Blood Cell count)	500
Evacuation	2,000	Blood grouping and matching	1,000
D&C	2,000	Blood slide for malaria parasites	500

Source: Field data. (US \$ = USH 1000)

* Grade A is the private wing, where payment is fee for service. Grade B is the public wing. In practice, Uganda's problems with service provision, there may be little difference in service between the wings.

** A patient pays a dental assistant USH 1000. If the dental assistant refers the patient to the dentist, the patient pays USH 1000 more.

Table 2. Fee Structure of District Hospitals, Rakai District (in USH)

Specification of Fees	Amount
OPD	500
Inpatients (per night)	500
Private wing	1,500
Deliveries	4,000
Major operation*	10,000
Minor operation**	5,000
Cesarean section	15,000
Female sterilization	3,000
X-ray	4,000
Laboratory tests, simple blood slide	500
Urinalysis and blood exam	500
VDRL + STD tests	1,500
Vidal screening	1,500
Dental charges	1,500
Medical form (book)**	200

Source: Field data.

*Major operations include appendectomy, abdominal surgery, chest surgery, hysterectomy, and mastectomy.

** Minor operations include circumcision, treatment of abscesses, sutures, tubal ligation, repair of hernia, and biopsy.

*** Following the breakdown in the service delivery system, health units did not even have the official medical forms. Patients were required to provide blank sheets of paper on which health workers would prescribe the medications. In some cases health units improvised medical forms, several sheets bound together, which would be sold to patients. At Rakai Hospital, this raised controversy as it was priced at twice that of its equivalent from the general shops.

Data show that, unlike the hospitals, which collected an average of USH 2 million in user fees per month, the average monthly collections for the lower health units was USH 200,000. In Rakai district, user fee collections were retained at the health units and spent accordingly, while in Mukono district, all fees were remitted to the district and integrated into the district budget. On average, 39 percent of the user fee collection was allocated to the health workers' welfare in the form of "top-up" to their low central government wages.⁶ Drugs took 18 percent, while charcoal, paraffin, and soap together took 15 percent. Allowances for health unit management committee (HUMC) members were subject to the availability of funds; in some instances, HUMC members did not get any form of payment. Table 3 below shows the breakdown of general monthly expenditures of user fees in Rakai district.⁷

⁶ In Rakai district, what each health worker received in "top-up" allowances at the end of each month depended on the size of the monthly collections.

⁷ User fee expenditure could not be obtained in Mukono district since collections are remitted to the district and integrated into the district budget.

Table 3. Monthly User Fee Expenditure, Rakai District (US\$)

Item	Monthly Average/Unit	Percent of Total Expenditure
Staff benefits(top-up)	75,000	39
Drugs	35,000	18
Transport	12,000	6
Bicycle repair	9,500	5
Charcoal, paraffin, soap	30,000	15
Stationery	13,000	7
Repairs and maintenance	9,500	5
Construction	00	00
HUMC	1,250*	1
Miscellaneous	7,000	4
Total	195,250	100

Source: Field data.

* At times the HUMC members would go without any financial benefits.

3.1.2 District Contributions to Health Budgets

District contributions to health as a sector were also small and MCH received very low percentages of this contribution. Tables 4 and 5 show the allocations in Mukono district; no figures were available for Rakai district.

Table 4. District Budgetary Allocations to the Health Sector, Mukono District, 1997/98

	1994/95	1995/96	1996/97	1997/98
District budget allocation to health as a sector (as percentage of all other contributions to the health sector)	US\$ 952,178 (11.9%)	US\$ 899,932 (8.2%)	US\$ 155,805 (12%)	US\$ 509,980 (14.5%)
District contribution to health sector as a percentage of the district budget	19.8%	18.3%	24.9%	16.7%
District contribution to MCH as percentage of district contribution to health sector	—	—	—	9.0%

Source: Field data.

Table 5. District Contribution to MCH, Mukono District, 1997/98

Program Item	Amounts (in USH '000)
Start four new parishes for health day campaign	2,320
Maintain 54 static units and repairs of refrigerators	3,447
Procure and distribute 20 weighing scales to 30 health units	5,000
Carry out 412 outreaches daily in 65 units	5,040
Collect, store, distribute, and vaccinate eight times monthly by two officers. Daily allowances and transport costs	Consolidated*
Procure and supply 45 kits and bicycles for traditional birth attendants and community health workers	8,250
Procure and distribute gloves and antiseptics	2,500
Sensitize women 14-49 years in 15 parishes about the need to have supervised deliveries	4,000
Procure and distribute gumboots, drugs, chairs, tables, filing cabinets, and four family planning spaces	5,000
Compilation of family planning data to establish popular methods	600
Procure, distribute, and use drugs for puerperal sepsis and hemorrhage	-----
Total	36,157

Source: Field data.

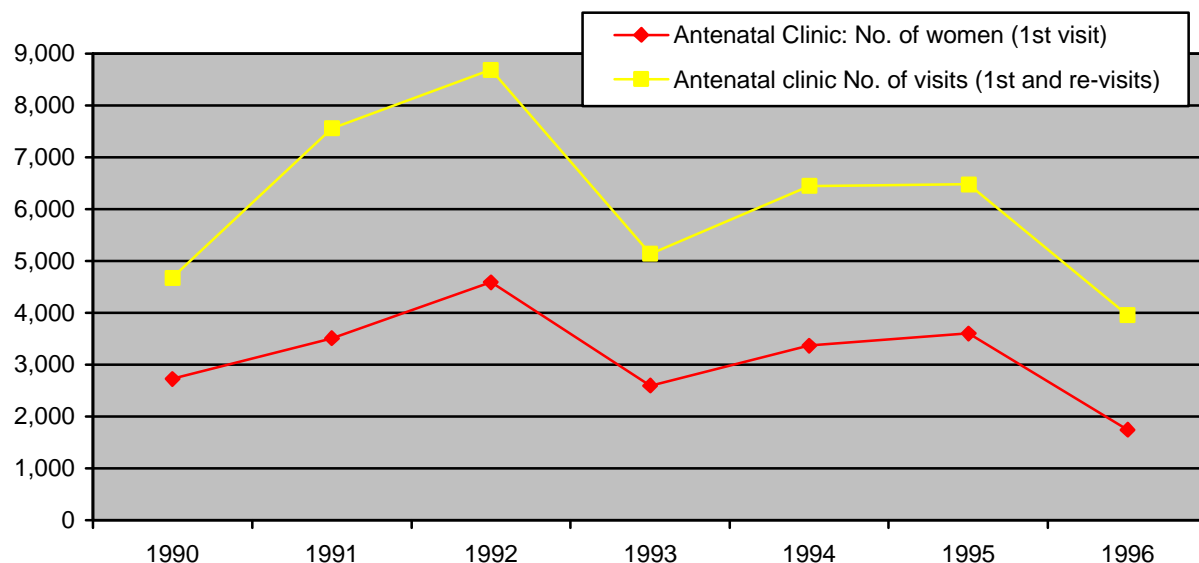
* Allowances were consolidated into the monthly salaries

3.1.3 Maternal and Child Health Service Utilization Trends

Formal MCH services started with the introduction of western medicine in Uganda by missionaries, notably Dr. Albert Cook's wife Sr. Timpson, who started the training of African midwives. This service steadily grew alongside the general health service system. When the health service delivery system broke down, MCH services broke down too.

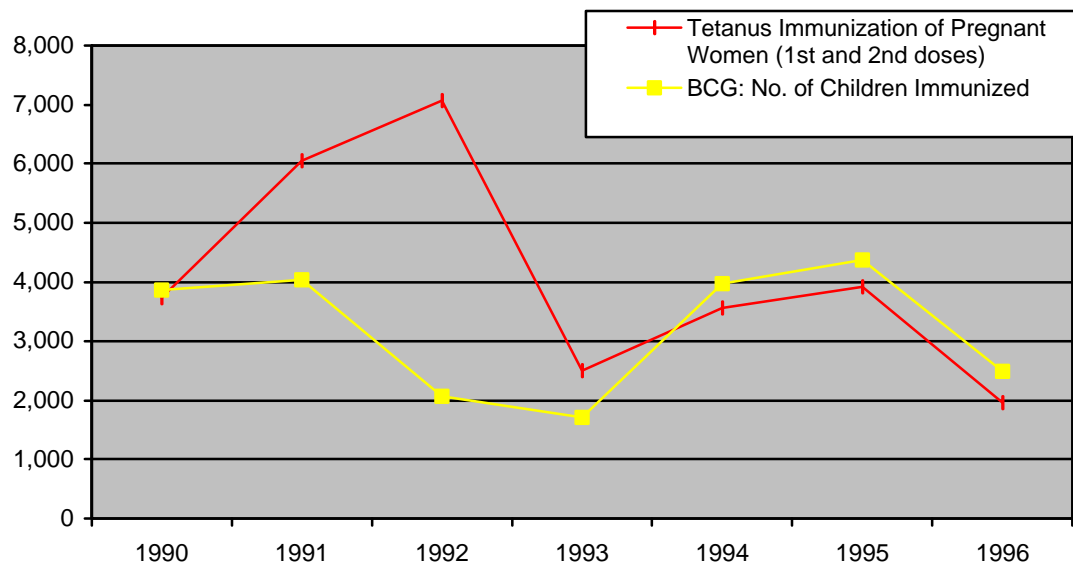
In the early 1980s, the Uganda National Expanded Program on Immunization, supported by UNICEF, saw a resumption of these MCH services. By the 1990s antenatal attendance was on an upward trend but started to fluctuate in 1995 and has declined since then. Graph 1 shows the trends in antenatal attendance.

Graph 1. Antenatal Attendance, Rakai District



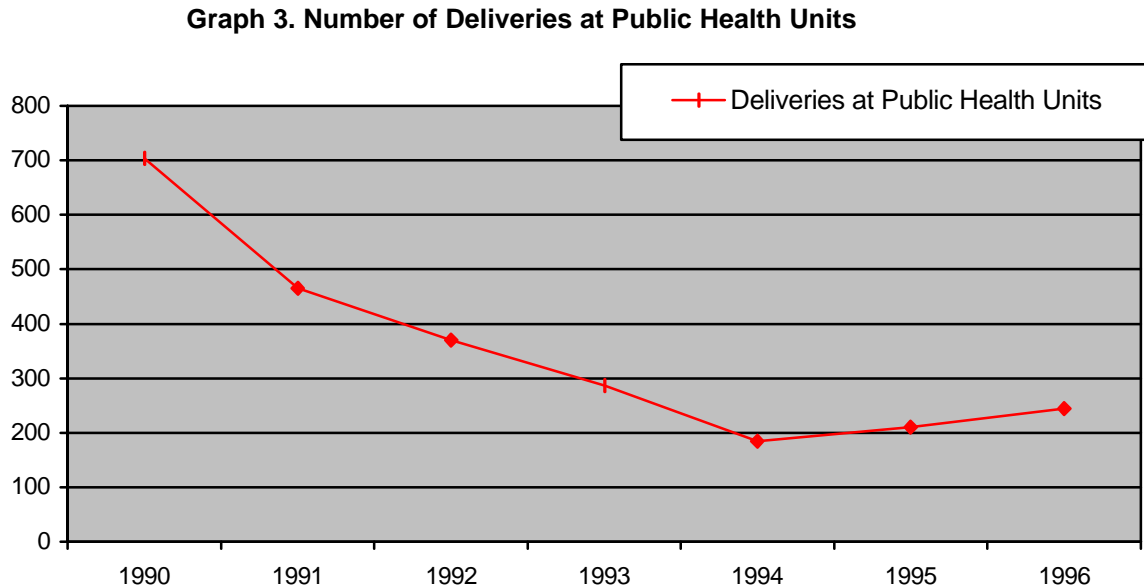
Graph 2 illustrates utilization trends in two selected immunizations. It shows a rise in tetanus immunizations between 1990 and 1992 and then a sharp decline in 1993, ironically the year during which more decentralized powers were granted to the districts. BCG immunizations also declined in 1993. Both immunization rates improved in 1994–95, though tetanus never regained its 1992 level, and declined again, to a level lower than in 1990. It is not easy to pin this decline entirely on the introduction of user fees, but it is clear that user fees did not lead directly to the expected higher service quality and higher utilization. Even when the services are provided essentially free of charge, users view the nominal fees paid under the user fees scheme as charges which should be matched with improvements in the delivery system.

Graph 2. Utilization Trends in Tetanus and BCG Vaccinations



Graph 3 shows trends in births at public health units. The number of women delivering at the public health units declined during the early 1990s, only picking up slightly from 1994 onwards.

Graph 3 shows trends in women deliveries at public health units.



Contrary to the expectations that decentralization would bring to MCH services a wide range of benefits (increased funding, prioritization, etc.), this has not necessarily happened. District budgetary allocations to MCH services are minimal, user fee revenue is minimal, and user charges for MCH services (particularly at hospitals) are relatively high compared to those for other services. There have been no visible improvements in the quality of services, and consequently utilization has remained low.

4. Analysis

4.1 User Fees—Poor People Paying for Poor Services

The main goal of introducing fees in public health units was to generate income that would significantly supplement both the central government allocations and donor funds. It was also argued that, since health service users were already making under the table payments, it would be only wise to legitimize such payments. A number of studies (Mwesigye-Runumi, 1995, 1997; Konde-Lule and Okello, 1998; Kisubi and Mugaju, 1999) have focused on the impact of the user fees on utilization, equity, willingness of users to pay, quality of services, and the political concerns of legitimacy. This has tended to shift attention away from the question of how much revenue can be generated? What proportion of the entire budget of a given health unit is covered by user fees? How is the income from the user fees spent or, rather, prioritized? Are user fees being spent on both curative and preventive services? How do poor communities, with very poor or no health facilities, cope?

The Ministry of Health estimates the requirements (recurrent excluding the salaries) of a lower health unit such as a dispensary at USH 5 million shillings a month. This was used as a benchmark against which to gauge the contribution of user fees towards the financing of health services.

On average, collections from user fees per month stood at USH 200,000 per health unit. This represents approximately 1.1 percent of the recurrent costs excluding salaries for each unit. In the worst circumstances this dropped to about USH 40,000. Clearly this is too small to make any significant positive change either in levels of drugs, staff salaries, or any other aspect of health care.

Moreover, MCH is a priority service affecting the most vulnerable groups, yet charges for these services are relatively high and this presumably negatively affects accessibility of these services for the poor.

The system fails to distinguish between those who are able to pay and those who are not, and also fails to cater to those who can only pay at a later date. Certainly there is evidence of modalities for clients to pay at a later date. More importantly, it fails for the reason of poverty. At Luwala hospital in Soroti district for instance, the mission hospital has suffered a great deal from low revenue collections due to the client's failures to pay or settle their carried forward bills. People would sometimes deposit their most valuable assets, like bicycles, as security to guarantee their commitment to settle bills, but would fail to redeem their assets. Money determines who gets services and who does not.

Expenditure of user fee revenue has been less debated than the charging of fees. One of the arguments, based on the Bamako Initiative's policy recommendations, has been that the money collected should be spent where it is collected. Since the user fees schemes are a result of district initiatives, administration and expenditure of the income from the user fees are under the discretion of the districts. For instance, until 1995, Rakai district authorities required the health units to remit all the proceeds from the user fees to the district finance office. This money would form part of the district revenue and was integrated into the budget. Health units protested against remitting their revenues to the district administration. Consequently, the district administration relinquished claims over the user fees funds but directed that all user fees collections and expenditures be reported to the

District Medical Office on a monthly basis. On the other hand, in Mukono district, user fees funds continue to be part of the district revenue.

4.2 Poor Districts, Poor Health

Revenue generation under decentralization suggests that a significant portion of district revenue should be locally generated. However, local revenue in the two districts under study was still very minimal. Figures for the 1997/98 district budgets indicate that Mukono district only managed to realize 22 percent of total budgetary requirements in this way, and Rakai district could only generate 1 percent. Despite decentralization, districts have to find financing for their health budgetary needs from the central government, donors, and NGOs. Where district revenue remains very limited, it means the voiceless—women and children—suffer the brunt of poor revenues. For example Mukono district allocated only 1.2 percent of the local revenue to MCH, which represented 15.5 percent of the total budget to the MCH care sub-sector, leaving the bulk of the financing of the MCH sub-sector to the donors.

4.3 More Autonomy, More Dependence

Decentralization has given a wide berth to local initiatives and control of political and administrative power but without actual resources to back up this power. This weakens the local district governments and grants both the central government and other actors, notably donors and NGOs, more influence.

Although donors and NGOs have had a long time presence in Uganda, their roles are changing from one of “filling the gap” between the central government and disadvantaged groups, to one of policy influence and practical implementation.

Local district revenue in both Mukono and Rakai covers just about 22 percent and 1 percent of their needs, respectively. It means that influence can be exerted from elsewhere, creating a multiplicity of principals with different demands, different priorities, and different approaches. A large part of the central government contribution to the district budgets is earmarked (conditional grant, 98 percent). Yet still this covers only part (approximately 40 percent) of the district budget requirements. The districts have to look for the rest from somewhere—and they usually look to donors and NGOs. Most donor and NGO funds also come with conditions. These conditions range from the use to which the funds are put, to the implementation and accounting procedures. Practically the districts are left with very limited locally generated revenue that they can freely allocate.

Since the districts are granted a wide range of autonomy to initiate and implement their own programs, the onus is on them to attract support outside of the central government. With an already over-stretched local resource base, aid becomes the only viable alternative. Where the district local government has to seek approval of tenure of office from the electorate on the basis of its capacity to improve the service delivery system, aid becomes politicized. The district local politicians have to adopt a kind of “Open Door” approach granting a wide range of choice for donors to design and implement their own programs. Here the districts are not only willing to accept all donor-funded programs but also donor conditions. These conditions have taken a more significant political role with the currently growing intolerance with corruption from both the local population and the donor community.

Significantly district roles with respect to vertical donor-funded programs as well as the district programs are being taken away. For instance, the districts are being required to subcontract to NGOs for implementation of the World Bank-funded District Health Services Project. In Rakai, where the corruption issues in the district's political and administrative circles have taken center stage, tough conditions have been set by the Danish Agency for International Development (DANIDA), the district's major donor. These conditions range from requiring the district to cede the implementation of the DANIDA-funded programs to NGOs and private companies, with DANIDA taking a supervisory role on the district administration. Specifically, DANIDA supervises the district administration and is free to withdraw its confidence, should the need arise, in a particular district civil servant or group of civil servants. In such an event, such civil servant or group of civil servant must be relieved of their duties or else DANIDA would suspend its assistance.

The funding and implementation of health services by a multiplicity of actors—central government, district local government, donors, and NGOs—is quite complex. Programs of different sizes are designed and implemented at different levels and at different times for quite varying periods. These programs range from infrastructure development and rehabilitation to those of a preventive nature, with donor and NGO programs emphasizing the preventive approach. Practically, the bulk of the MCH programs are funded and implemented by donors and NGOs. The NGOs usually see their roles as temporary; the general feeling is that the district should be able to take over from them. What actually happens is that district fails to take over, and the situation goes back to square one waiting for another NGO to intervene in the situation. However, this self-perception of NGOs as temporary service providers belies their actual institutionalization into the district service system whereby donors are increasingly relying on them to channel their assistance.

As noted earlier, the districts seem to be playing a decreasing role in the formulation and implementation of donor-funded programs. Apart from the mistrust in the districts' administrative machinery due to corruption, this trend is further reinforced by the feeling that districts lack the capacity to deliver services. Often cited as an example is the lack of an accumulated capital base—offices (with equipment), transport means, manpower, etc.—for which NGOs are said to have a comparative advantage. However, this argument seems only to serve the purpose of institutionalizing the NGOs. Notably Rakai district may have well over 70 percent of the district bureaucracy filled with university graduates. With massive support from DANIDA, the district service sector is arguably more than equipped with equipment, transport means, etc.

In the preceding paragraphs, mention was made of the complex nature of the district health service delivery that has evolved, and the multiplicity of principals with whom the district must work, how this translates into the local politics, and how it impinges on the setting of district priorities and service delivery. In practice, the relationship between the districts and the donors/NGOs is very similar to that between the donors and the central government. There are procedures and practices such as the donors' conferences where district policy dialogue and negotiations for aid are done on a regular basis. Here, the district would simply present its needs to the donors/NGOs and the latter give their position not only in matters of financing but also in matters of policy and priority setting. For instance DANIDA induced and facilitated the downsizing of the district workforce in Rakai from 2,000 civil servants to less than one half of that. Mukono district, which has no such backing, still has over 2,000 employees, excluding teachers. Now with the World Bank's District Development Project (DDP), Mukono might begin to retrench its 30 sub-county and 186 parish chiefs and replace them with graduates, because it is envisaged that the graduates would better cope with the new challenges of decentralization. Though this looks positive, the less educated staff may in fact have had nothing much to do with the current problems of poor prioritization, poor implementation of programs, drug leakage, corruption, etc.

At the local politics level, identifying oneself with aid to the district becomes the major source of political capital to contest for political office. Local members of parliament and the districts' political leadership restlessly strive to identify themselves with aid. Issues such as one's ability to attract aid and fight aid-related corruption usually dominate the local political campaigns. In Rakai particularly, where aid flow has been massive in recent years, there are correspondingly more aid-related political squabbles than in Mukono district, where aid is comparatively lower, though not small. Such scenarios have tended to shift attention away from the districts' most pressing needs and the multiplicity of players at different levels with different programs of different sizes, different objectives, and different approaches, which make it difficult to have a sector-wide approach. This in turn leads to inequitable delivery of services between geographical areas and subsectors.

5. Conclusion

Decentralization is potentially positive. Already tremendous success over a wide range of issues has been registered, especially in placement of manpower. There is no other period in the history of Uganda when district local administrations have been able to attract and employ such a number of well qualified personnel. However, the envisaged bottom-up approach to policy formulation and decision making has remained elusive. Local governments are often only consulted or simply invited to provide support for the implementation of vertical programs. Although the responsibility for planning and funding of primary health care including maternal and child health care programs is placed with the local governments, these continue to be planned, funded and implemented in the form of vertical programs, mainly by donors and NGOs through the MOH. And since the NGOs/donors do not cover the whole country or an entire district, but rather choose between the geographical locations within a district and between activities, they fragment many districts' priorities and programming. This detracts from equitable provision of services geographically and across the health sector. Districts are still unable to allocate more funds to MCH services and user fees continue to be prohibitively high in regard to MCH services.

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